modivcare

Virginia Retroactive Claim Form

Client's Name: _____ Date of Birth: _____
Last Name First Name MI

Home Address:_____
Street City ST ZIP

Medicaid #: _____ Primary Care Physician: _____

Eligibility Verified with: _____ Effective Medicaid Date: _____

Medicare #: _____ Other Insurance: _____

Trip Details

Transportation Provider: _____

Date of Transport: _____ Appointment Reason: _____

_____

Level of Service: □Ambulatory □Wheelchair □ Stretcher □Van Stretcher

Justification for Wheelchair/Stretcher/Van Stretcher Transport: _____

_____

Place of Pick-Up_____
Name of Facility

Address:_____
Street City ST Zip

Place of Drop-off: _____
Name of Facility

Address:_____
Street City ST Zip

Transport Requested by: _____
Person requesting transportation

Contact No.: (____)_____ Date of Request: _____

Form completed by: _____ Title: _____

□ Patient Care Report Attached □ Medicare EOB Attached □ VA MODV Trip Log

Stretcher retroactive claims will not be reviewed without the above attachments. A Medicare EOB must be attached when applicable. Attach a separate MODV invoice and trip log for each retroactive claim.

For Office Use Only:

Date Received: _____ Trip No. Assigned: _____ Name of Specialist: _____